Know critical care billing, documentation requirements: Don't put your career on the line because of fraudulent reporting, overcoding

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by Robert S. Gold, MD

Physicians who take chances by skirting ethics to increase their revenue risk massive financial penalties and the possibility of losing their freedom.

One Philadelphia hospital group was forced to pay $30 million in fines for fraudulent billing.

New Jersey's Blue Cross and Blue Shield recovered more than $10 million from physicians who billed for procedures with inappropriate codes or without ever having performed the stated procedure.

Medicare recovers thousands of dollars daily from physicians who bill a higher professional level than that which the patient's actual acuity level validates. The physicians do this with the erroneous assumption that no one will ever investigate them. Insurers' investigations often reveal healthcare providers who bill for services they never rendered; products they never delivered; misrepresented, unbundled, medically unnecessary, or duplicate services; increased units of services; false cost reports; kickbacks-and the list goes on.

Understand critical care requirements

I am aware of several hospitals where physicians bill for critical care interventions when a patient is not critically ill according to the organization's definition. A Google search for "critical care coding fraud" may persuade some of you to reconsider what you are doing in your daily work as an intensivist, as a critical care physician, or as a hospitalist. This may be in adult medicine, emergency medicine, pediatric medicine, or neonatal medicine. This may be Medicare, Medicaid, or any other payer. It is universal-it is ubiquitous.

Does this mean you should never bill a critical care code? Not at all. Any physician who deals with life-and-death situations deserves to bill for the harrowing experiences of critical care. But be certain that your ducks are in a row. Be aware of the clinical circumstances that validate critical care, the documentation requirements for billing for a patient intervention, the time requirements, and the diagnostic issues involved.

Know the documentation requirements

Some physicians examine one patient while a resident examines another-and the attending physician bills for both by signing the resident's work. As the attending physician, you must do the work yourself.

Sure, you can work alongside the resident. You can be there and participate in the history taking, the physical examination elements, and the procedures. And the resident can indeed write the note. But your obligations don't end there. You must identify that you were present during the patient interaction, that you examined certain body areas, that you participated in the procedure (even if the resident inserted the Swan-Ganz catheter while you supervised), and that you agree with the conclusions that the resident documented with or without variations or specific modifications.

You also must indicate that you spent a cumulative number of minutes dealing with that intervention. And don't forget that coders must be able to convert the diagnoses that you and the resident agreed upon into ICD-9 codes that indicate how critically ill the patient is.

Physicians have questioned the circumstances that warrant billing critical care. It is these questions that lead many physicians down a garden path with the belief that they are doing it correctly. A patient's mere presence in the intensive care unit (ICU) does not warrant billing critical care. A patient sent to the ICU to recover from major surgery and for reversal from anesthesia, weaned from the ventilator and extubated, is not critically ill. A patient sent to intensive care with his or her abdomen packed open after a liver transplant is there so he or she can remain on a ventilator to avoid abdominal compartment syndrome-not because he or she is critically ill.

The issue is "acute," "life-threatening," "illness or injury." A physician may purposely maintain a patient on a ventilator as discussed in the previous paragraph. This is not critical illness. Sure, the physician is maintaining the patient on a ventilator, and yes, without the ventilator and paralytics, the patient would die. But the act of taking the patient off the ventilator is what would make him or her critically ill. As long as the physician is properly maintaining the patient using the ventilator, the patient is stable.

Consider the following excerpts from Medicare's guidelines for billing critical care, which are inserted into every payer's Medicare Services Local Medical Review Policies (visit www.empiremedicare.com/newypolicy/policy/em002e01.htm for more information):

> ***Indications***
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> *The patient's condition must be such that there is a high possibility of sudden and clinically significant or life-threatening deterioration that requires the highest level of physician preparedness to intervene urgently.*
>
> *Critical care services include, but are not limited to, the treatment or prevention or further deterioration of central nervous system failure, circulatory failure, shock-like conditions, renal, hepatic, metabolic, or respiratory failure, postoperative complications, or overwhelming infection.*
>
> *Critical care may be continuous or interrupted, and may be provided on multiple days, even if no changes are made in the treatment rendered to the patient, provided that the patient's condition continues to require the level of physician attention described above.*
>
> ***Limitations***
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> *The mere presence of the patient in an ICU or [critical care unit], or the patient's use of a ventilator, is not sufficient to warrant the billing of critical care services.*
>
> *The treatment of a patient in a critical care unit, for conditions unrelated to the organ system requiring critical care, does not warrant billing critical care services.*
>
> *The physician service must be medically necessary and meet the definition of critical care services as previously described in order to be considered for reimbursement. Services that do not meet the criteria for critical care will be recoded to an evaluation and management (E&M) service at the appropriate level, based upon medical documentation.*
>
> *Critical care services billed by a physician may not include delegated services, (i.e., services by other healthcare professionals, including residents, house staff, nurses and other nonphysician practitioners.)*
>
> *In teaching hospitals, time spent by a resident may not be added to the total time billed by the attending physician for critical care. For services to count as critical care, the teaching physician must be present for the entire period of time that the services are delivered. Those services do not include time spent teaching or for the education of the resident or nursing staff.*

A patient whose septic shock has ended, whose acute respiratory failure has ended, whose acute renal failure is recovering nicely, who is sitting up, and who is eating breakfast, is not critically ill. So, don't set yourself up for scrutiny, fines, and loss of license by coding the patient as such. Learn the rules, follow them, be ethical, and help your coworkers to do it correctly as well.

Editor's note: Robert S. Gold, MD, founded DCBA, Inc., in Atlanta, a consulting firm that provides physician-to-physician programs in clinical documentation improvement. The goals are data accuracy, profile management, and compliance, either in the inpatient or outpatient arenas. Contact him by phone at 770/216-9691 or by e-mail at DCBAInc@cs.com.

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